

Advocate Comments

Virginia Hemophilia Foundation /Hemophilia Association of the
Capital Area

Virginia Chapter of the National MS Society

March of Dimes, Virginia Chapters

Brain Injury Association

Virginia Association of Community Services Boards and
Commonwealth Autism Services

Virginia Poverty Law Center



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April 2, 2012

The Virginia Hemophilia Foundation (VHF) and the Hemophilia Association of the Capital Area (HACA) are grassroots organizations representing people with bleeding disorders who live in Virginia. We appreciate the opportunity to comment on the February 2012 *Preliminary Analysis of Essential Health Benefits, Benefit Mandates, and Benchmark Plans (EHB Analysis)* prepared for the Virginia Health Reform Initiative.

VHF and HACA have approached our review of the *EHB Analysis* from the viewpoint of advocates for individuals who live with **serious, life-long, rare, and expensive** health conditions -- specifically, hemophilia and other clotting deficiencies. Bleeding disorders do not fit neatly into the model of most health insurance plans, which tend to focus on care for acute, episodic medical needs, rather than on the management of life-long, chronic conditions. There is no cure for hemophilia and related conditions, though fortunately there now are effective therapies that can sustain life and alleviate or eliminate the pain, joint destruction, and long-term disability that used to be hallmarks of these disorders. The necessary treatment comes at an extremely high price, however: upwards of \$250,000 per year, **for life**, for an individual with a severe form of the disorder.

At the outset, we note that existing Virginia law requires individual and small group policies to cover hemophilia and congenital bleeding disorders ([§ 38.2-3418.3](#)). The *EHB Analysis* correctly recognizes that such coverage comes within the scope of the essential health benefits packages under the Affordable Care Act. Hemophilia benefits are included in all of the benchmark plans surveyed for the *EHB Analysis*. Thus, hemophilia coverage (as mandated by existing Virginia law) does not fall within the small category of state-mandated benefits that exceed the scope of the essential health benefits package.

The remainder of our comment will address what must be included within the essential health benefits package to make its coverage meaningful for individuals with bleeding disorders. We will focus on three areas in particular: access to the full range of available therapies; comprehensive care; and limits on benefits, including cost-sharing.

The standards of care for a rare and chronic condition should be based on medical literature and treatment guidelines recommended by the health care specialists that have expertise with the particular disorder. In the case of hemophilia and other genetic bleeding disorders, the [Medical and Science Advisory Committee](#) (MASAC) of the National Hemophilia Foundation has established [quality of care guidelines](#) that are recognized as setting the standard of care for the treatment of these rare disorders. One of MASAC's key standards stipulates that patients with bleeding disorders should have [access to](#)



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the full range of available therapies. There is no generic product that exists for the treatment of hemophilia and other bleeding disorders. Clotting factors – the treatment required to stop bleeding in people with clotting deficiencies – are complex biological products that produce varying responses in different patients. Restrictive drug formularies would limit patient access to critically needed therapies and thus should not be included in benchmark plans.

MASAC's standards of care also specify that patients with bleeding disorders must have access to comprehensive care, i.e., regular access to specialized hemophilia treatment centers (HTCs). Over 30 years ago, the federal government backed the creation of a nationwide network of HTCs, recognizing that hemophilia and other clotting deficiencies were poorly understood and rarely encountered by most doctors. The idea was to gather together in one clinical setting medical professionals with expertise in all facets of bleeding disorders: hematologists, nurses, physical therapists, social workers, orthopedists, dentists, and (once blood-borne HIV and hepatitis infections cut a deadly swath through the hemophilia community) infectious disease specialists. Studies by the U.S. Centers for Disease Control confirm the effectiveness of this treatment model, showing a 40% reduction in mortality and morbidity for individuals with hemophilia who visit an HTC at least once a year. Data also show that annual HTC visits significantly reduce hospital and nursing visits, and decrease the average cost of care per patient. The comprehensive care model, in other words, provides an effective – and cost-effective – “medical home” for individuals with bleeding disorders. Comprehensive care, i.e., regular access to HTCs (as well as access to a full range of treatments at all other appropriate sites of care) must be included as an essential health benefit under all benchmark plans.

Finally, cost-sharing provisions of benchmark plans must be carefully evaluated to ensure that patients with expensive and life-long diseases such as hemophilia are not denied access to life-saving and life-sustaining medical care. Individuals with bleeding disorders rely on expensive therapies for which no generic substitutes are available. Therefore, plans must be transparent about deductibles, co-pays, and co-insurance amounts applicable to both in- and out-of-network coverage. In addition, specialty tier pricing for prescription drugs must be prohibited. A percentage co-insurance charge applied to essential therapies that cost tens of thousands of dollars per month would make those medicines unaffordable and unavailable to the vast majority of patients who desperately need them. We recommend that Virginia put in place an oversight mechanism to review benefit designs ensuring that cost-sharing does not discriminate or unfairly target any patients with rare diseases.

Kelly Waters
VHF Executive Director

Karen Krzmarzick
HACA Executive Director

March 29, 2012

Virginia Health Reform Initiative Advisory Council

Re: “Virginia Essential Benefits Report”

Dear Members:

The National Multiple Sclerosis Society is grateful for this opportunity to comment on the Preliminary Analysis of Essential Health Benefits, Benefit Mandates, and Benchmark Plans report submitted by PricewaterhouseCoopers in February, 2012. We offer these comments on behalf of the estimated 11,000 Virginians currently living with multiple sclerosis.

Multiple Sclerosis (MS) is a chronic, often disabling disease that attacks the central nervous system, including the brain, spinal cord, and optic nerves. Symptoms may be mild, such as numbness in the limbs, or severe, such as paralysis or loss of vision. The progress, severity, and specific symptoms of MS are unpredictable and vary from one person to another. Although there is still no cure for MS, effective strategies are available to modify the disease course, treat exacerbations, manage symptoms, improve function and safety, and provide emotional support. In combination, these treatments enhance the quality of life for people living with MS.

The Society has identified several health services and medicines that are most likely to achieve optimal health, wellness and quality of life for persons with MS. These include some benefits that are routinely limited, subject to inconsistent interpretation, or excluded altogether in most individual and small group plans on the market today, including Chronic Disease Management, Habilitative and Rehabilitative Services and Devices, Mental Health and Prescription Drugs. We are pleased that these benefits have been included in the 10 categories outlined by the Department for Health and Human Services. We understand that Virginia now has the opportunity to determine how these benefits will be provided through a Benchmark plan and we offer the following suggestions:

- **Chronic Disease Management:** We believe that “enhancements to the coordination of care, particularly for those with complex chronic conditions, can produce improvement in quality care and increased efficiencies.” To achieve these goals, improve patients’ safety and help prevent secondary conditions in people with MS, chronic disease management programs must be truly inter-disciplinary and patient-centered (i.e., reflective of informed consumer choice of provider, treatment options, anticipated results and side effects). The assurance of unfettered access to coordinated primary and specialty care in the least restrictive setting possible is essential to the successful application of chronic disease management concepts to the ongoing care of persons with MS.
- **Rehabilitative Services and Devices:** The National Association of Insurance Commissioners defines rehabilitation services as “health services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled” (see ‘ Summary of Benefits and Coverage and Uniform Glossary: Templates, Instructions, and Related Materials under Public Health Service Act’) and the Society strongly recommends the use of this definition in our EHB package. For persons with MS, rehabilitation to keep, get back or improve function include physical, occupation and speech/language therapy services, or combination of these services. These interventions may be required from health professionals with expertise in any one or these areas. Evaluation of function or

impairment through the use of standardized tools can require a different skill set than the interpretation of test results and their application to treatment plans. Durable medical equipment, which for people with MS can vary from a simple cane to highly customized power wheelchair, is also presumed to be included in this category and critical to the provision of quality MS care.

- **Mental/Behavioral Health:** We are pleased to see HHS' explicit reassurances regarding parity in mental health benefits. Because people with MS experience higher rates of depression than the general population, various interventions may be required and highlight the need for safeguards regarding medical necessity.
- **Prescription Drugs:** In the bulletin issued by HHS, the Department proposed a standard for prescription drug coverage (one drug per category or class) that could severely curtail access to available agents that help people with MS manage their disease. We note that even the current US Pharmacopeia Model Formulary for Medicare Drug Plans includes seven MS agents under the same class and category (<http://www.usp.org/hqi/mmg/>), and most health plans include most if not all of them in their formularies. People with MS need and deserve access to the therapeutic agent(s) offering the greatest possible benefit with the fewest side effects, and there is no single agent, category of agents or mechanism of action best suited to them all.

For the MS community, the high cost of prescription medication is also a concern. Several health plans have instituted a tiered payment system for medication. The most expensive medications are often relegated to the highest "specialty" tier which requires enrollees to pay a *percentage* of the medication as opposed to a fixed co-pay. With no generic alternatives available, MS disease-modifying therapies are typically assigned to this specialty tier. This places an unjust financial burden on people with MS. We recommend that as you look at essential health benefits, you also look for ways to spread the risk related to the high cost of prescription medication. Furthermore, we suggest that Virginia develop an oversight mechanism that evaluates whether cost-sharing arrangements in various plans create adverse selection. If adverse selection is found to occur, there should be rules to assure equivalence in drug cost-sharing. As an example: in the state of Washington, a provision was added into their Health Benefit Exchange legislation which states:

The [insurance] commissioner shall evaluate plans offered at each actuarial value defined in section 1302 of P.L. 111-148 of 2010, as amended, and determine whether variation in prescription drug benefit cost-sharing, both inside and outside the exchange in both the individual and small group markets results in adverse selection. If so, the commissioner may adopt rules to assure substantial equivalence of prescription drug cost-sharing.

Virginia State Mandated Benefits

Mandated benefits are hard-won state laws that are vital to consumers with many health care needs. Benefits such as telemedicine are valuable to Virginians who may have limited mobility and inadequate access to specialists and accessible transportation. It is important to carefully review all potential Benchmark plans and select one that includes our state mandates.

We appreciate the initial analysis done by PricewaterhouseCoopers, comparing the potential Benchmark plans and the services they cover. We recommend analyzing each benefit category with more specificity. We need to understand the full extent and scope of coverage for each benefit category before making a comprehensive comparison of plans.

Thank you again for this opportunity to comment.
Sincerely,

Ashley Chapman
Virginia State Advocacy Manager
National MS Society



March of Dimes Foundation

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Pat Simmons
State Director

COMMENTS ON THE VIRGINIA ESSENTIAL HEALTH BENEFITS
ANALYSIS REPORT TO THE VIRGINIA HEALTH REFORM INITIATIVE

April 4, 2012

On behalf of the March of Dimes, we appreciate the opportunity to submit written comments on the Virginia Essential Health Benefits Analysis report to the Virginia Health Reform Initiative. The March of Dimes Virginia Chapters has followed this issue with great interest and I wanted to let you know our priorities for the essential health benefits package. We hope you will take these thoughts into consideration.

The mission of the March of Dimes is to improve the health of women of childbearing age, infants, and children by preventing birth defects, premature birth, and infant mortality. The March of Dimes supports access to health care coverage for all women of childbearing age, infants, and children. Health insurance coverage affects how people use health care services. People who are underinsured report poorer health status. They are less likely to have a usual source of medical care and more likely to delay or forgo needed health care services. Therefore, the benefits and services that will be included in Virginia's Essential Health Benefits package will be of great concern to consumers.

As you make decisions concerning the selection of a state benchmark health plan, we would like included in Virginia's Essential Health Benefits package the following:

- Coverage of the full scope of maternity care services, including preconception care, labor and delivery, and postpartum care as recommended in the American Congress of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics' (AAP) Guidelines for Perinatal Care.
- Coverage of all infant and child care services included in AAP's *Scope of Benefits Policy Statement*.

In addition, these benefits should minimize cost sharing, and any imposed visit limits should be based on medical necessity.

As the analysis noted, if one of the three small group plans with the largest enrollment is chosen as the benchmark plan, maternity and newborn services would need to be added to that plan. Whichever benchmark plan is chosen, or used to add maternity and newborn services to another benchmark plan, those maternity services need to include the full spectrum of preconception care, labor and delivery, and postpartum care. Women who receive preconception care are able to have access to screening and diagnostic tests that can help to identify problems early; services to manage developing and existing problems; and education, counseling, and referral to reduce risky behaviors like substance abuse and poor nutrition. Such care may help improve the health of both mothers and future babies. Postpartum care is vital to help women appropriately space pregnancies, thereby reducing the risk of preterm birth.

We are also interested in learning more about the optional coverage for obstetrical services offered or covered by the potential benchmark plans. Having a better understanding of those services is important in determining whether they should be included in the Essential Health Benefits package.

Thank you for your attention and consideration of our requests.

Yours truly,

Pat Simmons
Chapter Director

Thank you for providing stakeholders with the opportunity to comment on the report on Essential Health Benefits submitted by PriceWaterhouseCoopers to the Virginia Health Reform Initiative (VHRI). The Brain Injury Association of Virginia exists to be the voice of brain injury through help, hope and healing for Virginians with brain injury and their families. We educate human service professionals and the community on the risks and impact of brain injury and advocate for improved medical and community-based services.¹ Wearing the lens of service providers for the population with brain injury, we present our comments.

Brain injury is the last thing on your mind until it's the only thing.TM Just ask the millions of children and adults who sustain brain injuries in the U.S. each year. News reports of returning veterans and recent high profile brain injury stories indicate what researchers have been reporting for years—brain injury is a leading public health problem in U.S. military and civilian populations.²

The prevalence of brain injury is significant. According to the Centers for Disease Control and Prevention (CDC), each year 1.7 million American children and adults seek treatment for identifiable traumatic brain injuries (TBIs) from falls, car crashes and other external blows to the head.³ An estimated 1.6 to 3.8 million individuals annually incur sports-related concussions but do not seek immediate treatment. Additionally, each year nearly 1 million Americans sustain acquired brain injuries (ABIs) from strokes, infections, tumors, toxins and metabolic causes.⁴ In Virginia, an estimated 28,000 individuals sustain a traumatic brain injury each year, and nearly 1,400 die. Additionally, an estimated 184,000 citizens of Virginia are disabled as a result of brain injury.

No two brains are alike, and therefore no two brain injuries are alike. Any brain injury—regardless of cause, type or severity—can temporarily or permanently affect brain and body functions resulting in difficulties in physical, communicative, cognitive, social, emotional, and psychological performance that undermine health, function, community integration, and productive living.

Brain injury also predisposes individuals to re-injury and the onset of other conditions. These conditions include, but are not limited to epilepsy, vision and hearing impairments, psychiatric disorders, and orthopedic, gastrointestinal, urologic, sexual, neuroendocrine, cardiovascular and musculoskeletal dysfunction.

¹ Brain Injury Association of Virginia. www.biav.net.

² Brain Injury Association of America: Covering the Treatment Continuum for Persons with Brain Injury as Part of National Health Care Reform. 2009.

³ Faul M, Xu L, Wald MM, Coronado VG. Traumatic brain injury in the United States: emergency department visits, hospitalizations, and deaths. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2010.

⁴ Brain Injury Association of America. Covering the treatment continuum for persons with brain injury as part of national health care reform. April 23, 2009.

For many individuals who sustain brain injury, the effects may be minimal and when properly treated, full recovery or nearly full recovery is possible. However, the CDC estimates that each year, at least 125,000 brain injury survivors will develop a permanent disability, and therefore, the onset of chronic disease. Approximately 53,000 persons die from TBI-related injuries annually.⁵

The PriceWaterhouseCoopers report lists the Essential Health Benefits to be included in health insurance policies regulated and/or issued by and within the Commonwealth, and it compares several existing policies as benchmarks. We are pleased that the Affordable Care Act mandates benefits that include services needed by people suffering from brain injury. These include emergency, ambulatory care, hospitalization, and rehabilitative/habilitative services. However, the report does not delineate the extent of such services. With these comments, we present a framework for the services that should be included for people recovering from brain injury. The Brain Injury Association of America, in response to an Institute of Medicine survey on Essential Health Benefits, stated that services for people recovering from traumatic brain injury should adhere to the following precepts:

- Be **patient-centered** and **consumer-directed** to the maximum extent so that informed choices can be made;
- Provide **access** to trained, qualified and appropriately credentialed **health care personnel** to allow for the best outcomes sooner for special populations;
- Utilize providers who understand the **unique health needs** of different populations so that they can help plan and coordinate care to better address the needs of the individual;
- Include **preventive services**, incorporating services to prevent the worsening of a disability or condition that is secondary to a disability;
- Provide a **comprehensive array** of health, rehabilitation, assistive device and support **services** across all service categories and sites of service delivery;
- **Allocate resources** by investing in services that will eliminate or reduce the need to spend more later in a person's life.⁶

Rehabilitation is the single most effective medical treatment known for facilitating neuro-regeneration following brain injury. Rehabilitation is composed of surgical, pharmacological, medical and therapeutic interventions and is unique in that unlike any other field of medicine, it requires the contributions of a wide variety of medical and therapeutic disciplines. These services must do the following:

- Prevent, mitigate, reverse or arrest neurophysiological disease processes.
- Speed recovery (better outcomes and enhanced likelihood of discharge to one's home, living longer and retaining a higher level of function post injury or illness);
- Improve long-term cognitive and physical function, improve overall health status and improve the likelihood of independent living and quality of life;
- Decrease the likelihood of homelessness, joblessness, impoverishment, family system disintegration and medical indigence;

⁵Morbidity and Mortality Weekly Report. May 6, 2011. Surveillance for Traumatic Brain Injury—Related Deaths—United States, 1997-2007.

⁶ Brain Injury Association of America. December 6, 2010. Responses to IOM survey questions. Unpublished.

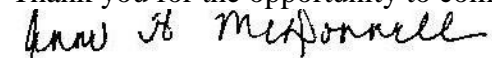
- Decrease reliance on various public health and assistance programs;
- Halt or slow the progression of primary and secondary disabilities (maintain functioning and prevent further deterioration); and
- Facilitate return to work in appropriate circumstances.

When addressing the continuum of services that many individuals recovering from traumatic brain injury require, BIAV recommends that the essential benefits **do not place arbitrary limits** on these services. For example, many insurance carriers recognize the importance of access to treatment in accredited and licensed alternative medical settings and choose to exchange skilled nursing benefits to cover rehabilitation in alternative settings. Unfortunately, the skilled nursing benefit is usually limited to 100 days per year or less. Thus, the approach imposes an arbitrary time constraint to providing medically necessary treatment for neuromedical diagnoses despite strong support in the research literature for treatment of sufficient duration and intensity for maximum clinical and cost effectiveness. In addition, some insurance companies, have “dollarized” the skilled nursing benefit, further restricting rehabilitation access to a specific dollar amount. No other disease condition is similarly constrained. Cardiac or cancer treatments are not limited by days of treatment or to an amount approximating \$70,000 per year. It is inconceivable that diseases of the brain should be treated in this manner.

Persons with acquired brain injury may attain a plateau in functional restoration prior to entering a secondary recovery phase. For this reason, individuals with certain chronic conditions **should have options for access** at any point along the treatment continuum throughout their lives. Further, we recommend that when improvement or progress toward identified treatment goals stagnates, decisions to terminate treatment be made by the patient, family and treating medical professionals and not the insurers.⁷

In summary, we ask that the VHRI consider essential benefits that cover the standard of care for persons with brain injury - early, intensive acute treatment and rehabilitation, followed by timely post acute rehabilitation of sufficient scope, duration and intensity to restore maximum function and accommodate residual disability.

Thank you for the opportunity to comment on this policy matter.



Executive Director

⁷ National Institutes of Health. (1998). Rehabilitation of Persons with Traumatic Brain Injury: NIH Consensus Statement. In U.S. Department of Health and Human Services (Ed.) (Vol. 16, pp. 1-41): National Institutes of Health.

Virginia Association Of Community Services Boards, Inc.

Making a Difference Together

TO: VHRI
FROM: Virginia Association of Community Services Boards (VACSB)
Subject: Comments Regarding Virginia's Essential Health Benefits

Thank you for the opportunity to comment upon the analysis conducted by the VHRI contractor and also for the opportunity to comment upon what should be included in Virginia's Essential Health Benefits Plan from the perspective of services addressing behavioral health and developmental disabilities.

The VACSB represents Virginia's Community Services Boards (CSBs) and one Behavioral Health Authority (BHA), who have extensive experience in developing, managing, and providing services for individuals with behavioral health conditions and developmental disabilities in their communities. We have drawn upon that expertise to shape our comments as well as information, expertise and support from Commonwealth Autism Services, an organization that shares our comments about coverage for Developmental Services and Autism Spectrum Disorders.

It was disconcerting to learn from the contractor that, for the most part, behavioral health services are not well-defined; however, Virginia now has the opportunity to define them well, based upon the consistent and well-documented results that individuals with these conditions have achieved when appropriate services have been provided. As the population increases, the numbers of individuals with behavioral health and developmental disabilities increase. Both our ethics and our economy demand provision of the most cost effective and results-oriented services, those services that have been proven to avoid more restrictive and expensive levels of care.

Based on CSB/BHA experiences since 1968, we are recommending that essential behavioral health services include:

I. Two Tiers of services for behavioral health conditions

Tier I services should consist of those services that are considered traditional behavioral health services designed to address and resolve a wide variety of mental health and substance use disorders. Our recommendations are more fully developed in the sections below.

Tier II services should consist of intensive behavioral health services that may continue for an extended period of time and serve to avoid hospitalizations of children and adults who have serious mental illness, serious emotional disturbance, severe or co-occurring substance use disorders and who are so impaired by their illnesses that they need considerable assistance in remaining in their communities and providing for their basic needs. Our recommendations for Tier II services are also developed in the following sections along with case examples that illustrate the need for intensive services and what provision of those services has accomplished.

- II. **Rehabilitation Services** which are critical for individuals with any developmental issues
- III. **Early Intervention Services** for infants and toddlers with developmental disabilities which are further developed in the following sections along with case examples.
- IV. **Services for Autism Spectrum Disorders** developed in the following sections with a case example.

I. Behavioral Health Services:

Tier I- Medically Necessary Coverage- Mental Health/Substance Abuse Disorder

Criteria: Tier I services include mental health and substance use disorder services for children and adults that meet medical necessity criteria and are in parity with services for all other medical conditions.

Outpatient Services

Delivered through all Licensed Mental Health Professionals and includes assessment, evaluation, diagnosis, counseling

- Outpatient psychotherapy covered when medically or psychologically necessary to treat a behavioral health disorder. Outpatient psychotherapy may include any combination of individual, family, group, or collateral sessions designed to help identify issues and begin a recovery process.

Intensive Outpatient Services for behavioral health conditions.

Structured individual and group activities and services that are provided at an outpatient program designed to assist adult and adolescent consumers to begin recovery from substance use disorder/addiction and learn skills for recovery maintenance. Types of services and treatments include:

- Individual counseling and support;
- Group counseling and support;
- Family counseling, training or support;
- Biochemical assays to identify recent drug use (e.g. urine drug screens);
- Strategies for relapse prevention to include community and social support systems in treatment;
- Life skills;
- Crisis contingency planning;
- Disease Management; and
- Treatment support activities that have been adapted or specifically designed for persons with physical disabilities, or persons with co-occurring disorders of mental illness and substance abuse/dependence or intellectual/developmental disability and substance abuse/dependence.

Crisis Intervention

- Direct behavioral health care for non-hospitalized individuals, available 24 hours a day, 7 days per week, to provide assistance to individuals experiencing an acute mental health dysfunction requiring immediate clinical attention. Crisis Intervention can be provided for an individual with co-occurring mental health and substance abuse services as long as treatment for the substance abuse is intended to positively impact the mental health condition.
- Objectives of crisis intervention should include preventing exacerbation of a condition, preventing injury to the recipient or others, and providing treatment in the least restrictive setting.
- Pre-admission screenings as defined in the Code of Virginia for involuntary detention or admission for involuntary detention or involuntary admission to hospitalization.

Note: Reimbursed Telemedicine via videoconference can and should be used to deliver these individualized OP services that lend themselves to telemedicine. Telemedicine systems must be HIPAA compliant and meet secure standards to be reimbursed.

Crisis Stabilization

- Provided in a variety of settings, the service is direct mental health care to non-hospitalized individuals of all ages who are experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. Individuals must demonstrate a clinical necessity for this service arising from a condition due to an acute crisis of a psychiatric nature which puts them at risk of psychiatric hospitalization
- Crisis stabilization should avert hospitalization, provide normative environments with a high assurance of safety/security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system, family members and others for discharge to on-going maintenance and rehabilitation.

Medication Management

Prescription medications and management for a behavioral health condition must be under the care of a provider who is authorized to prescribe those drugs. The provider manages the dosage and duration of prescription medication and may authorize or request authorization for laboratory tests as indicated by the use of a medication. Medications shall be administered only by persons who are authorized to do so by state law and only to the individuals for whom the medications are prescribed.

Pharmacy Services

Virginia's Essential Health Benefits should prohibit a "fail-first" policy in using psychotropic drugs for mental illness or using drugs for medically-assisted treatment for substance use disorder.

Laboratory Services

The use of psychotropic drugs and drugs for medically-assisted treatment often necessitates tests that indicate blood, metabolic, and other levels to assure that the patient's conditions are within appropriate guidelines for use of the medication.

Partial Hospitalization

A psychiatric partial hospitalization program (PHP) is recommended when a provider believes it is necessary to stabilize a critical behavioral health disorder that does not require 24-hour-a-day care in an inpatient psychiatric setting, or to transition from an inpatient program to an outpatient program. A PHP is a treatment setting that provides medical therapeutic services at least three hours per day, five days per week. Treatment may include day, evening, night, and weekend programs.

Medically Monitored Detoxification

Medically Monitored Detoxification, provided in an inpatient or crisis stabilization setting, is used to treat severe cases of withdrawal. Individuals needing this level of care require evaluation, 24 hour nursing care, supervision by a physician and withdrawal management, and are not likely to complete detox on their own due to situations that inhibit the process such as having a co-occurring psychiatric illness, physical condition or additional substance use disorders that may intensify withdrawal, further complicating the detox process. A physician or nurse practitioner is present on a daily basis to oversee the administration of care and prescribe necessary medication and is on-call 24/7. Nursing staff is employed at all times. The effectiveness of Medically Monitored Detoxification is best enhanced with discharge follow-up typically provided in a partial hospitalization program, intensive outpatient, or outpatient treatment services program.

Psychiatric Inpatient Hospitalization

Individualized stabilization, treatment and medication for a behavioral health condition provided within a licensed psychiatric hospital or a licensed psychiatric unit within a general hospital during which time the individual remains in the hospital twenty four hours a day until inpatient care is no longer necessary. The plan for inpatient care is based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care. During inpatient care, discharge planning is conducted by a team of professionals in consultation with the recipient and, if a minor, the parents, legal guardians, or others in whose care they will be released after discharge and will include an integrated program of therapies, activities, and experiences designed to ensure continuity of care for the recipient upon discharge.

Rationale for Intensive (Tier II) Services for Severe and Chronic Behavioral Health Conditions

For children and adults whose illnesses and functioning levels are such that they have grave difficulty acknowledging their services needs and caring for themselves, certain Tier I services will be needed in conjunction with more intensive levels of services and supports. The VACSB is identifying these intensive services as Tier II services and they are developed below.

To meet criteria for Tier II services, there must be evidence of severe and recurrent disability resulting from mental illness or substance use disorder. The disability must result in functional limitations in major life activities.

Individuals should meet at least two of the following criteria on a continuing or intermittent basis:

- 1) Is unemployed; is employed in a sheltered setting or supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.
- 2) Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
- 3) Has difficulty establishing or maintaining a personal social support system.
- 4) Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
- 5) Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.
- 6) The individual is expected to require services of an extended duration, or the individual's treatment history meets at least one of the following criteria:
 - The individual usually has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime or
 - the individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

Intensive Tier II services are necessary to assure the highest degree of community integration and to assure the lowest cost level of service.

Tier II Services for Behavioral Health Chronic Care Management/ Disease Management

Case Management

Case Management is the core service that Virginians with severe behavioral health and developmental disabilities need to help navigate and coordinate needed services. It includes the elements of care coordination and a full range of care and support that individuals with severe disabilities require in order to live successfully in the community and avoid higher and more expensive levels of care. These services include supportive counseling, crisis intervention, coaching, assessment and discharge planning, relationship building, teaching decision making, self-advocacy and wellness planning, educating regarding the need for medication, primary care and therapy, promoting continuity of care among various health systems and providers, providing family education and support, and overcoming barriers for accessing appropriate care.

Case Example for Case Management

Client, 54, has diagnoses of Schizophrenia, Paranoid Type with Cocaine, and Alcohol Addiction. He has been involved in some level of treatment for over 20 years with his first psychotic episode in the early 1980s. He has a history of multiple hospitalizations in local hospitals and state hospitals and past attempts to engage him in numerous outpatient treatment modalities have not been very successful. Needing medication management, housing, and case management at the very least, his non-acceptance of these services has resulted in incarcerations in local jail, further local hospitalization, and periods of homelessness. With a history of physical, emotional and sexual abuse in childhood and teen years, he can become

aggressive and violent at times and protective orders have been issued against him by family members. With the help of his Case Manager, he obtained housing and, over time, accepted somewhat consistent Medication Management Services, Mental Health Support Services and some Psycho-Social Rehabilitation. Despite his persistent issues with other individuals, he remained stable enough to stay out of hospitals and jails, to avoid abuse of crack and alcohol, and has had no "dirty" urine screens throughout this time. He has gradually come to show a level of trust for members of his treatment team: his case manager, prescriber, nurse, and Psycho-Social Rehabilitation worker. The key with him has been treatment team's willingness to "start where he is" and do whatever we can to make being involved in services as attractive to him as possible. He still has little insight into how his behavior affects him or others but he remains out of hospitals and jails and willing to engage in treatment.

Psycho-Social Rehabilitation (PSR)

Psycho-Social Rehabilitation (PSR) is a program of two or more consecutive hours per day provided to groups of adults in a nonresidential setting. Individuals must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the individual about mental illness, substance abuse, and appropriate medication to avoid complication and relapse. PSR offers opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment. Psychosocial rehabilitation includes skills training, peer support, vocational rehabilitation, and community resource development oriented toward empowerment, recovery, and competency in living in the community.

Psycho-Social Rehabilitation Case Example

The success of one Virginia Psychiatric Rehabilitation program illustrates the importance of the service. The program has served 88 individuals who have experienced mental health and/or co-occurring conditions of intellectual disability or substance use. The PSR program offers individuals a place to come, meaningful work, and a place to return through their recovery process. Before becoming a "member" of the program, these clients experienced long term psychiatric hospitalizations, stays as long as 6 and 7 years and some as many as 10 stays in a 14 year period. Members had no routine, place of employment, or housing, and utilized the emergency room, public streets, and or loitered around stores for a place to go which often resulted in criminal charges. These negative consequences changed shortly after joining the program.

From April 10, 2008 to October 4, 2011, 88 members celebrated 100% community tenure - meaning no one was admitted to a psychiatric facility. Members are expected to attend the program on a routine basis and work side by side with clinicians to accomplish the daily program operations, which are achieved in a structured setting that provides a work day routine atmosphere. Members see value and acknowledge their journey to recovery; many have made employment gains by working in the transitional employment placement program. The employment program has endeavored to support the Governor's Employment First initiative. There are 20 current members in the employment program, which represents over 20 % of the membership. They are proud to report that three members have independent full and part- time Positions. Others have been employed for years and continue to be successful

since fully integrating into the community. As a whole, the members have participated in many community projects such as sending care packages to soldiers stationed in Afghanistan, all the while avoiding hospitalization and the pitfalls of a previously unstructured life outside of the program.

Mental Health Support Services (MHSS)

Mental Health Support Services (MHSS) are defined as training and supports to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. The following components are reimbursed: training in or reinforcement of functional skills and appropriate behavior related to the individual's health and safety, activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals who, without these services, would be unable to remain in the community and would be in placed in institutions. The individual must have two of the following criteria on a continuing or intermittent basis:

- Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that the individual is at risk of psychiatric hospitalization or homelessness or isolation from social supports;
- Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition or managing finances to such a degree that health or safety is jeopardized;
- Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary;
- Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

Case Example for Mental Health Support Services

Client is 49 years old and has spent much of his adult life struggling with addiction, schizophrenia, and homelessness, in and out of shelters, hospitals, outpatient programs, and the streets. He refused a placement in an independent housing program and engagement in services. His condition declined, he suffered increased symptoms of paranoia and agitation from inconsistent medication adherence, and his life became mired in conflicts with neighbors, roommates, and landlords, often unable to pay rent and utilities. In the space of 5 months, client experience repeated hospitalizations. After discharge, he was evicted due to safety concerns stemming from his habit of hoarding from local dumpsters. During the eviction proceedings, client was arrested for disturbing the peace and served 25 days in a correctional facility. As a condition of his release, he agreed to participate in a program that included engagement in Mental Health Support Services, case management, and Psycho-Social Rehabilitation. With intensive MHSS support several times per week, client became more invested in his recovery and accepted services.. He eventually moved into a supportive housing program, where MHSS staff provided daily on-site supports, training, and skills development. This treatment proved successful, as client has experienced no hospitalizations, graduated

from the program and transitioned into an independent housing program. He continues to remain substance free, lives independently and meets with MHSS staff several times per week. This would not have been possible without the MHSS, case management, and psychosocial rehabilitation structure.

PACT/ICT Services

PACT (Program of Assertive Community Treatment) or Intensive Community Treatment (ICT) is a service-delivery model that provides comprehensive, community-based treatment for those with serious and persistent mental illnesses. Unlike other programs, PACT provides the individualized, multidisciplinary, 24/7 staffing of a psychiatric unit, but within the person's own home and community. PACT/ICT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation.

An evidence-based practice, PACT/ICT is a self-contained interdisciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a full- or part-time psychiatrist. This team assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses, including those who have severe symptoms that are not effectively remedied by available treatments or who because of reasons related to their mental illness resist or avoid involvement with mental health services. PACT/ICT provides services on a long-term care basis with continuity of caregivers over time and delivers 75% or more of the services outside program offices. PACT/ICT is offered to individuals who have had repeated hospitalizations, issues with medication adherence or medication resistance, whose functioning levels prohibit an ability to care for themselves, and who need consistent outreach and monitoring.

Case Example for PACT/ICT

Client, diagnosed with serious mental illness, from 1989 until 2004 experienced "whirlwinds of being hospitalized, becoming better, and in the hospital again." Client remembers little about those years except for being in civil commitment hearings and other court hearings, wondering what happened and "why Saddam Hussein was sitting in those hearings" with her. In 2004, client again was hospitalized in a local psychiatric hospital "when the CSB PACT team met with me and offered an array of intensive services and a place to live. The team saw me every day, and assured that I took medication, that the medication worked for me, that I had support of whatever kind when I needed it, and did whatever it took to move me on a recovery path." In 2012, client has "graduated" to a less intensive service, is married and is involved in assisting other individuals move into more recovery focused living.

Tier II Services For Children and Youth

Criteria: Children and adolescents (birth-17) must demonstrate serious emotional disturbance, defined as a serious mental health problem that can be diagnosed under the DSM-IV, or the child must exhibit all of the following:

- Problems in personality development and social functioning that have been exhibited over at least one year's time; and
- Problems that are significantly disabling based upon the social functioning of most children that age; and
- Problems that have become more disabling over time; and
- Service needs that require significant intervention by more than one agency.

Children must demonstrate a clinical necessity arising from a severe condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

1. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community; and/or
2. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary; and/or
3. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior. For example, child is at risk for acting out in such a fashion that will cause harm to self or others.

These services are used to intervene early and prevent out of home services and higher levels of care.

Intensive In-Home Services for children and youth

Provided typically in the home of consumer at risk of out-of-home placement or being transitioned to home from an out-of-home placement due to a documented medical need of the child. IIH includes crisis treatment, individual and family counseling, communication counseling, case management activities, coordination with all other services the child receives, and 24-hour emergency response.

Two of the following criteria must be clearly documented for the individual on a continuing or intermittent basis:

1. Problems in establishing / maintaining interpersonal normal relationships such that are:
 - at risk of hospitalization or out-of-home placement because of conflicts with family or community
2. Show such inappropriate behavior that repeated interventions by
 - mental health
 - social services or
 - judicial system are necessary;
3. Demonstrate such difficulty in cognitive ability that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

Case Example for Intensive In-Home Services

Client was 17 years old when she was referred to the CSB and was on probation with a history of severe behavioral health disorders and failed attempts at outpatient treatment. Client was habitually truant from school, was failing classes and frequently ran away. Her suicidal actions had resulted in four psychiatric hospital stays. She was using illegal drugs which finally culminated in arrest and probation. Her out of control behaviors continued despite numerous attempts with traditional outpatient services and she was at significant risk of an out of home placement. She began receiving Intensive In-Home services three to five hours per week. A psychiatrist monitored her medication and, with eventual compliance, she stopped making

attempts on her life and started going to school on a regular basis. Her parole officer and several teachers advocate for her, citing her compliance with rules and improved attitude toward accepting responsibility for her actions. She plans to finish high school and has age appropriate friendships that encourage positive activities as opposed to negative actions and hospitalizations. She has now stepped down from Intensive In-Home services and is receiving outpatient therapy from the CSB.

Therapeutic Day Treatment for youth

This is a treatment program for children and adolescents through age 17 and, under certain circumstances, up to 21 with serious emotional disturbances, substance use, or co-occurring disorders. Also eligible are children from birth through age seven who are at risk of serious emotional disturbance, in order to combine psychotherapeutic interventions with education and mental health or substance abuse treatment. Services include evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills, and individual, group, and family counseling. This service may be school-based or center-based.

Case Example for Therapeutic Day Treatment

Client was a 12 year-old when he was referred to therapeutic day treatment (TDT) and had just been released from 12 months in residential treatment. The recommendation of the residential treatment center was a discharge to group home but he was brought home with TDT and intensive in-home services in place. Client was diagnosed with schizo-affective disorder with psychotic episodes. He was aggressive at home and had assaulted his mother and younger brother. He had difficulty getting through the school day without aggressive outbursts and displayed poor social skills and development.

Through the TDT classroom at his middle school, he began to stabilize. Intensive in-home services were helpful with the transition and were discontinued after 6 months. He transitioned to TDT in high school, where he was able to learn social skills, temper management, and began making friends. He entered the vocational technology program, which would have been impossible without the daily support of the TDT classroom. He graduated from high school in June of 2011, and his mother gave a positive report of the client, who now has a full-time job and has been able to maintain his gains with regular support of TDT.

Rehabilitative Services

Rehabilitative Services should include Occupational Therapy, Physical Therapy, and Speech Therapy based on medical necessity, need for service and duration of service, and in parity with all other medical conditions.

Developmental Services

Current Virginia Mandate for Early Intervention up to age three should be maintained

Developmental Services provided up to at least the age of 3, and in parity with other medical coverage for infants and toddlers meeting the Early Intervention criteria.

Early Intervention Services are medically necessary speech and language therapy, occupational therapy, physical therapy, assistive technology services and devices, and other developmental services provided to infants and toddlers from birth to age three who are certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). "Medically necessary early intervention services for the population certified by the Department of Behavioral Health and Developmental Services" shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

Early intervention services are provided for infants and toddlers who have a 25% delay in development, who are developing atypically, or who have a diagnosed condition that will likely result in a developmental delay. Services are defined in federal regulations and include but are not limited to Occupational Therapy, Physical Therapy, Speech Therapy, Special Instruction/Developmental Services, Service Coordination/Case Management and are among the services listed in the federal regulations. Services must be provided by practitioners certified by DBHDS and under the direction of an Individualized Family Service Plan (IFSP).

Case Example for Early Intervention Developmental Services

Client was born very prematurely and diagnosed with a rare birth defect that would affect brain development. He was enrolled in Part C/Early Intervention services at just 26 days old, and received developmental services, occupational therapy, physical therapy, and speech therapy in his home. His entire family was involved in achieving a series of developmental goals, from crawling, walking, talking, eating on his own, and becoming more of an independent child at 3 years old.

When asked what made the difference for the client, his mother said that it was the whole "support team" around him from his earliest days of receiving services. Client now attends a special education program at school, has matured, and is able to accept new experiences.

Case Example for Early Intervention Developmental Services

Client was nine months old when he was referred to the Part C/Early Intervention program for concerns related to his unwillingness/inability to take food or liquid and subsequent poor weight gain. He was diagnosed with Failure-to-Thrive (FTT) and was in danger of having a feeding tube because of his severe malnutrition. A developmental specialist came into the home with exercises intended to build oral and throat muscle tone so he could eat without choking and also worked to reduce food sensitivity since nutrition is vital to brain health. The creation of a customized plan was also vital to identifying what foods the client could manage safely and not reject.

His diagnosis of FTT was removed as his weight climbed and he exceeded goals. He continues to be monitored by the Part C program once every two months due to his risk factors but today he is a healthy 21-month old because of these services. When you teach a child who would otherwise not be able to eat on their own you are not only saving long-term healthcare costs, you are saving the child.

Autism Spectrum Disorder

Essential health benefits for ASD should include:

- Multi-disciplinary assessment for diagnostic purposes. This type of assessment uses established protocols to differentiate categories of ASD and to identify the most appropriate treatment. Investing in a multi-disciplinary assessment is cost beneficial because identifies treatment needs specific to the individual, rather than suggesting a battery of treatment options with limited efficacy based on an inaccurate diagnosis.
- Individualized Treatment depending upon the diagnosis should include, as indicated, the following (age appropriate):
 - Speech pathology;
 - Occupational therapy;
 - Physical therapy;
 - Applied behavioral analysis (ABA) targeting behaviors associated with the core deficits of ASD.

Each child must receive sufficient individualized attention and services on a daily basis to achieve adequate implementation of objectives. The hours will vary according to a child's chronological age, developmental level, specific strengths and weaknesses, and family needs. The priorities of focus include functional spontaneous communication, social instruction delivered throughout the day in various settings, cognitive development and play skills, and proactive approaches to behavior problems

- Coverage for autism should possess the following criteria:
 - Begins at diagnosis, which is based on multi-disciplinary assessment.
 - Covers services that implement basic principle of Applied Behavioral Analysis. Uses scientific behavioral data to identify functional relationships between environmental events and behavior.
 - Uses behavioral data to track progress in reaching behavioral objectives and periodically modifies the plan to adapt to the child's responses to interventions.
 - Includes parental/caregiver involvement to the extent possible, including training of parents and caregivers.

The National Autism Center has published the most current report of research on the scientific evidence for treatment of autism. The preponderance of research is on individuals 22 years and younger. Cost-benefit estimates for early behavioral intervention for young children with autism can be found on its website. A list of treatments by age can be found on the Commonwealth Autism Service website. However, because autism is a developmental disability, individuals should receive required services at the frequency recommended for as long as necessary. Some services will be life-long.

Case Example for ASD Services

Autism is called "autism spectrum disorder," because there is no one story of autism that is exactly like another. K. is 30 months old and is the youngest child in her family. She is not talking or playing like her older brother did when he was K.

K. loves to play with her daddy, but will sometimes get too excited and the play will end in a tantrum. K. says a few words, such as car, daddy, light, and doggie, but she does not use these

words with intention or appropriately; she tends to say them spontaneously while she is babbling or to herself.

At K.'s 24-month well-child check-up, her mother discussed concerns with the pediatrician. K.'s pediatrician completed the M-CHAT (an ASD screening tool) with K.'s mother's assistance and noted concerns for possible autism spectrum disorder. Subsequently, K. underwent a multidisciplinary assessment that confirmed autism.

Because of her diagnosis and age, K. is eligible for early intervention services. An individualized plan was developed that includes the following outcomes: learning to use words to communicate and improving ability to interact with the family during play and other daily routines. The treatment team, including K.'s family, determines that weekly speech therapy services will be the primary early intervention service offered to support K.'s family. Monthly occupational therapy is also included on the team plan to give K. parents and the speech therapist suggestions for activities to address K.'s sensory processing and fine motor needs.

As Virginia continues to shape its plan for Essential Health Benefits, it is critical to utilize the services and technologies that provide for the highest degree of health and wellness rather than rely upon disease management of acute conditions until they escalate into the highest and most expensive levels of care. By providing for an array of needs and developing adequate criteria to assure appropriate services based on those needs, Virginia can reduce its spending on health related conditions and enjoy healthier citizens and healthier communities.

Again, thank you for the opportunity to provide these comments. For questions, please contact Mary Ann Bergeron, mabergeron@vacsb.org or via telephone: 804.330.3141.

Attachments (separate file):

- HEDIS measures for individuals with serious mental illness (SMI)

Seven new care management measures for schizophrenia and bipolar disorder have been proposed for addition to the 2013 Healthcare Effectiveness Data and Information Set (HEDIS) for Medicaid. The new measures are intended to address identification and quality care management for people with serious mental illness who are at greater risk for morbidity and mortality from adverse outcomes due to lack of medication adherence, lack of preventive care, and gaps in treatment. The federal Department of Health and Human Services (HHS) included these new measures among the initial set of 26 quality measures for Medicaid-eligible adults released on January 4, 2012. The HHS quality measures are intended for state Medicaid agencies; use of the measures is voluntary.

On February 14, 2012, National Committee for Quality Assurance (NCQA) released the proposed measures for a one-month comment period, which closed March 14, 2012. This new set of proposed measures for SMI was based on 2011 research conducted by NCQA and Mathematical Policy Research. They conducted a field test to determine a baseline for the proposed measures using a Medicaid Analytic Extract; the dataset included fee-for-service data for beneficiaries in 22 states. About 10% of the Medicaid population in the data set was identified as having schizophrenia (98,412 individuals) and another three percent as having bipolar disorder (130,529 individuals).

2012 Mental Health-Related HEDIS Quality Measures For Medicaid-Eligible Adults

Measure	Description	NCQA Field Test Baseline Result
Use of Antipsychotic Medications for Schizophrenia Treatment	The percentage of members 25–64 years of age with a diagnosis of schizophrenia who remained on an antipsychotic medication for at least 80% of their treatment period.	An average of 65.7% of the individuals maintained continuous treatment with an antipsychotic for at least 80% of the time. The range across the states was 48.3% to 84.6%.
Schizophrenia/bipolar disorder and antipsychotic use: Diabetes screening	The percentage of members 25–64 years of age with a diagnosis of schizophrenia or a diagnosis of bipolar disorder, who were prescribed any antipsychotic medication and received a diabetes screening test during the measurement year.	An average of 12.1% of individuals received diabetes screening test. The range across the states was 2.3% to 28.2%.
Schizophrenia/bipolar disorder and antipsychotic use: Cardiovascular screening	The percentage of members 25–64 years of age who were diagnosed with schizophrenia or bipolar disorder and	An average of 43.9% of individuals received cardiovascular health screening. The range

	prescribed any antipsychotic medication, and who received a cardiovascular health screening during the measurement year.	across the states was 6.9% to 63.3%.
Schizophrenia and diabetes: Diabetes monitoring	The percentage of members 25–64 years of age who were diagnosed with schizophrenia and with diabetes, and received both an LDL-C test and an HbA1c test during the measurement year.	An average of 57.3% of individuals received LDL-C test and an HbA1c test. The range across the states was 9.1% to 81.6%.
Schizophrenia and cardiovascular health: Cardiovascular monitoring	The percentage of members 25–64 years of age with a diagnosis of schizophrenia and a diagnosis of cardiovascular disease, who received a cardiovascular health monitoring test during the measurement year.	An average of 54.5% of individuals received cardiovascular health monitoring test. The range across the states was 11.7% to 85.7%.
Cervical Cancer Screening for Women with Schizophrenia	The percentage of women 21–64 years of age with a diagnosis of schizophrenia who received one or more Pap tests to screen for cervical cancer.	An average of 24.4% of females in the sample received one or more Pap tests. The range across the states was 7.9% to 34.8%.
Follow-Up After Hospitalization for Schizophrenia at seven and 30 days	The percentage of members 25–64 years of age with a diagnosis of schizophrenia who had an outpatient visit, intensive outpatient encounter, or partial hospitalization following discharge from a hospitalization for schizophrenia.	An average of 36% of individuals received follow-up care at seven days and 69.7% received follow-up care at 30 days. The range across the states was 8.3% to 66.1% for seven days, and 25.6% to 88.5% for 30 days.



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April 4, 2012

TO: Virginia Health Reform Initiative

FROM: Jill A. Hanken, Staff Attorney

RE: Essential Health Benefits

Thank you for the opportunity to provide comments on Essential Health Benefits (EHB) and the PWC report.

I appreciate the work done by the consultant to provide a starting point for this discussion. However, the information in the PWC report is not sufficient to make a decision about the benchmark plan Virginia should use for its EHB. Critical information is lacking.

First, PWC acknowledges that more information is needed to accurately identify the potential benchmark plans:

“[S]ubstantial cooperation from the health plans in Virginia will be required to determine the small group plans with the largest enrollment in the state, particularly since the purchase of coverage riders for maternity and bariatric surgery, for example. . . will need to be considered in the determination of what is covered under the largest plans. Additional information on the benefit options selected by federal employees will also be required.” (p.5)

“Insufficient information is currently available with which to determine the largest non-Medicaid commercial HMO plan. To obtain this information will most likely require a data call to the HMOs operating in Virginia.” (p.5)

Selecting a benchmark plan is impossible without knowing exactly which plans can be considered.

Second, the PWC report contains almost no information about the actual scope of benefits covered by the various plans. We do not know enough about limits on visits; limits on coverage; or standards used to authorize services. Also completely lacking is information about excluded benefits. Without such details, how can one plan be measured against another?

PWC acknowledges that such details about coverage are missing:

“The extent to which plans cover behavioral health treatment is not clear.” (p. 4)

“In some cases, the plan summaries [on the internet] reflected detailed descriptions of benefit coverage and exclusions. In others, only high-level coverage descriptions ...were obtained, and coverage of certain benefits could not be determined....[F]ollow up with the health plans to obtain detailed summary plan descriptions is required to more fully understand coverage differences.” (p.6)

“It is possible and likely that other benefit limitations may apply to these and other services.” (p. 6)

“Coverage of certain benefits specified in the 10 EHB categories, specifically habilitative services and behavioral health treatment, is less clear as summary plan descriptions rarely specify coverage within these categories.” (p.7)

“At this time we do not know the extent to which employers in the small group market are purchasing these optional benefits.” [referring to mandated offers] (p. 7)

“Optional coverage offered to Individuals and Small Groups, such as non-formulary drugs and Virginia’s mandatory benefit offers will need to be evaluated to the extent they are included in the possible benchmark plans.” (p.8)

For purposes of comparison, I have attached a study on this issue completed for the state of Washington. This study contains significant detail about the range and scope of specific services offered within the ten EHB categories. The study also describes the relative “richness” of each plan as well as exclusions. The Washington study found over 40 specific services for which there were “meaningful differences” between the scope of services offered – including differences relating to limits on visits, monetary caps, or other restrictions. Many of these differences applied to commonly used services, such as home health care services, where limits ranged from 25 to 130 visits/year; outpatient rehab services ranged from 15 to 75 visits / year; and there were different limits on eyeglasses for children. The analysis of exclusions also shows wide variations.

Until we are provided complete, detailed analysis of each of the Virginia plans’ actual scope of services and exclusions, it is impossible to select a benchmark plan. I hope the VHRI will undertake the necessary research, so that consumers and all stakeholders will be able to fully analyze all the choices. Full transparency is essential as Virginia moves towards this critical decision.

As this process moves forward and the necessary additional data is collected from plans to select and design Virginia’s benchmark plan, there are many areas that will require special attention:

Services to children: Virginia's benchmark should include adequate vision services (including eyeglasses); dental coverage (following our FAMIS model); hearing aids; and therapy services for children with special needs (beyond age 3).

Mental Health, Substance Abuse, and Behavioral Health: Specific and detailed coverage will need to be defined. The mandated coverage for autism spectrum disorder should be included.

Maternity and Newborn services: Specific and detailed coverage will need to be defined.

Habilitative Services: The extent of coverage should at least be in parity with rehabilitation coverage. It is important that "maintenance of function" be included in the definition.

Prescription Drugs: The benchmark should include at least 2 drugs per category and include the typical 3-tier coverage (with the highest cost sharing for medications not on the plan's formulary.)

Hearing Aids and Vision Services for Adults: PWC notes differences in coverage in the potential benchmark plans. The benchmark plan selected should include the broadest coverage currently available in the alternative benchmark plans.

Medically Necessary Criteria: A standard definition should be included in the benchmark.

I appreciate VHRI's solicitation of stakeholder input on these very significant issues. Thank you for your attention to these comments.